

To:		Date:	
From:		Title:	
Office Location:		Office Phone:	
Office Address:		Office Fax:	

We received your request, or have gained knowledge of your need, to take leave under the Family and Medical Leave Act (FMLA) due to a serious health condition that makes you unable to perform the essential functions of your job. This is to inform you that you **are eligible** for leave under the FMLA, and the requested leave **will be counted** against your annual FMLA leave entitlement. Except as explained below, you have a right under FMLA to use up to 12 weeks of unpaid leave in a 12-month period for the specific reasons listed below. **For our purposes, the 12 month period during which the 12 weeks leave may be taken will be counted as a "rolling" 12 month period.**

(Examples of serious health conditions. These are just a few examples, they are not all-inclusive:

Birth (including prenatal appointments), adoption, foster care. Intermittent then continuous for surgery & recuperation. Continuous for hospitalization & recuperation. Intermittent physical therapy 3x/week for 6 weeks. Intermittent for 4 months for minor child's weekly medical appointments/treatment. Intermittent to transport parent to/from frequent medical appointments, therapy and care.)

We will begin counting your absence as FMLA beginning: through

Specific reasons for this FMLA approval due to serious health condition:

Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work, and you must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from leave. If you do not return to work following FMLA leave for a reason other than: (1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; or (2) other circumstances beyond your control, you may be required to reimburse the State for their share of health insurance premiums paid on your behalf during your FMLA leave.

1. You will not be required to furnish medical certification of a serious health condition if it has already been provided to us. **If the required medical certification has not been submitted, you must provide it within fifteen (15) days, no later than** _____.
2. Paid leave will be substituted for any unpaid family/medical leave in the following sequence: sick, annual and personal.
3. Your normal health insurance premiums will continue during the period of FMLA leave. The State will continue to pay its share of the group health insurance premium. If you go into unpaid status for an entire pay period, you will be billed for your portion of the premium. If you do not pay the bill for your portion of the health insurance premium while you are on unpaid status, your health benefits will be cancelled and you will ineligible for health benefits until the next open enrollment period.
4. You **will** be required to present a fitness-for-duty certificate prior to being restored to employment following a continuous absence of three or more days. If such certification is required but not received, your return to work will be delayed until such certification is provided.
5. While on leave, you **will** be required to furnish us with periodic reports **at least once per pay period** of your status and intent to return to work (see §825.309 of the FMLA regulations). If the circumstances of your leave change and you are able to return to work earlier than the date indicated above, you will be required to notify us at least two work days prior to the date you intend to report to work.
6. You **will** be required to furnish recertification every 30 days relating to a serious health condition, unless the minimum duration of the period of incapacity indicated on the medical certification you furnish is more than 30 days.